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**MENTAL HEALTH POLICY PAPER****Community-based mental health care in Africa: mental health workers' views****ATALAY ALEM<sup>1</sup>, LARS JACOBSSON<sup>2</sup>, CHARLOTTE HANLON<sup>3</sup>**<sup>1</sup>Department of Psychiatry, Addis Ababa University, P.O. Box 19241, Addis Ababa, Ethiopia<sup>2</sup>Department of Psychiatry, University of Umea, Sweden<sup>3</sup>Health Services Research Department, Section of Epidemiology, Institute of Psychiatry, London, UK

*The World Health Organization (WHO) has for long proposed the development of community-based mental health services worldwide. However, the progress toward community mental health care in most African countries is still hampered by a lack of resources, with specialist psychiatric care essentially based in large, centrally located mental hospitals. It is again time to reconsider the direction of mental health care in Africa. Based on a small inquiry to a number of experienced mental health professionals in sub-Saharan Africa, we discuss what a community concept of mental health care might mean in Africa. There is a general agreement that mental health services should be integrated in primary health care. A critical issue for success of this model is perceived to be provision of appropriate supervision and continuing education for primary care workers. The importance of collaboration between modern medicine and traditional healers is stressed and the paper ends in a plea for WHO to take the initiative and develop mental health services according to the special needs and the socio-cultural conditions prevailing in sub-Saharan Africa.*

**Key words:** Africa, community mental health care, primary care, continuing education

*(World Psychiatry 2008;7:54-57)*

In Western countries, community-based mental health services are now becoming the preferred model for delivery of psychiatric care, in contrast to the more traditional mental hospital-based services. The World Health Organization (WHO) is a proponent of such an approach, not only in the high- and middle-income countries of the West, but also in low-income developing countries (1). In the Western setting, the different elements of a community-based service are well-recognized and include closing down or down-sizing mental hospitals, the establishment of psychiatric units in general hospitals and the formation of community-based mental health teams. The latter are composed of psychiatrists, nurses, social workers, psychologists, occupational therapists and other mental health professionals, and provide outpatient and outreach services aiming to support patients in their homes wherever possible. Primary health care works in synergy with the specialized community-based service, with the expectation that the bulk of mental disorders will be managed in this setting by health workers who have received basic mental health training. The system often includes collaboration between social services in the local community, as well as the formation of close links with families, user organisations, charities and telephone information and support lines.

This model is not, however, directly applicable to low-income countries in Africa, where there is a great scarcity of trained mental health professionals and virtually no social service, and where families, traditional healers and religious leaders often play the dominant role in dealing with mental disorders. In many countries the number of mental health professionals is very low. In Ethiopia, for example, there are only 18 psychiatrists for 77 million people, and there is no clinical psychologist, no trained social worker and only one 360-bedded mental hospital located in the

capital, Addis Ababa (2). Likewise, to date, all psychiatrists are working in Addis Ababa, although psychiatric nurses provide hospital-based outpatient clinics in the regions (3). The situation is similar in other African countries, where the majority of mental health specialists work in the capital cities, leading to neglect of the rural areas (4). Many psychiatric hours are devoted to private practice, because of the poor remuneration within the government health system, further eroding the service available to the majority of the population.

The WHO has proposed the development of community mental health services through integration of mental health into the existing primary health care system and mobilization of community resources. The structure of the primary health care system in sub-Saharan Africa is reasonably well-established, although with variable coverage and quality of service. The model for primary health care is usually based on two or three levels. Closest to the community is the health post, where one or two health workers with very limited training provide basic medical and preventive care for a population of 1000-5000 people. At the next level are health centres, where registered nurses and sometimes doctors are working with a catchment area of 20,000-100,000 population. Above that there are district hospitals and regional hospitals, where sometimes there might be a psychiatrist or other specialized mental health worker, but most often not (4).

The mainstay of care for mentally ill persons in traditional African societies is not, however, accessed through primary health care at present. In Ethiopia, for example, only 33.4% of persons with persistent major depressive disorder had contacted governmental health services in the preceding three months (5). Families and the folk sector thus provide the lion's share of care. Compared to the

Western world, African society is much more tightly knit, with both stronger family coercion and greater social support. There is almost always an extended family to rely upon, and even severely ill persons are usually living with their family, although a minority of mentally ill persons may choose to move away from their families, often ending up as vagrants. Only in more extreme cases of violence or extremely deviant behaviour, or when the family's resources are stretched to breaking point, will mentally ill persons be excluded from their families, although they may be chained up or neglected. Overall, however, it is families, and to a lesser extent communities, who form the basis for mental health care in traditional societies.

Innovative strategies for delivering community-based mental health care in Africa have come and largely gone, with few initiatives sticking or proving possible to roll out on a broad basis. Pioneers of African psychiatry took promising initiatives to collaborate with traditional healers and to adapt services to the African socio-economic setting. The model village of Aro developed by Lambo in Nigeria (1954) is one example. Other examples are those of Henri Collomb in Senegal and Margaret Field in Ghana, who also developed collaboration with traditional healers, and of Tigani El Mahi and Taha Baasher in Sudan, who established working relationships with Muslim leaders to facilitate identification, referral and de-stigmatization of persons with mental illness.

#### **WHAT DO AFRICAN MENTAL HEALTH PROFESSIONALS THINK ABOUT COMMUNITY-BASED MENTAL HEALTH CARE?**

Three decades on from the WHO imperative to develop community-based mental health services in Africa, we conducted a small survey to explore how do mental health practitioners on the ground see the situation. What is the prevailing conceptualization of community mental health care, African style? A questionnaire was developed with questions on the basic elements required for a community-based mental health service approach for Africa, as well as on protective and negative factors in the traditional African society and how to support the positive aspects and counteract the negative ones. The questionnaire was sent out by e-mail to mental health workers in sub-Saharan Africa. Out of the 20 respondents, 15 were psychiatrists, of whom four were professors of psychiatry.

The survey emphasized the immense variation between African countries, as well as the differing needs of rural and urban settings. Linked to this, several respondents stressed the importance of not just diluting Western models, but instead developing culturally-sensitive approaches and models that can be adapted to the particular situation. Many respondents endorsed principles of care provision such as accessibility, comprehensibility and equity, which echo those guiding community mental health services in

Western settings (6). The lack of human resources and the difficulty retaining staff, especially in rural areas, was an important obstacle identified by the majority. Likewise, the necessity of finding ways to collaborate with traditional healers and spiritual leaders in order to facilitate detection, referral and rehabilitation of persons with mental disorders was mentioned by almost everybody. The community was also identified as important, providing a base of local expertise upon which mental health care might be built. Targeting the community for sensitization regarding mental disorders and anti-stigma campaigns was seen by most respondents as vital. Providing support to patients and their families was less often suggested.

Very few respondents spoke of the value of national mental health policies and only one person mentioned mental health promotion and mental illness prevention programmes. The broader context of mental health care was alluded to by several people, particularly the impact of poverty on mental health and provision of services. However, nothing was said about the impact of wars, forced displacement, societal transition and exposure to violence. Working with non-health agencies, such as educational services and the justice system, was not mentioned as an integral part of community-based mental health care.

There was notable uniformity of responses to the question on resources required for the development of a community mental health model. Almost everybody thought that there should be some kind of mental health community worker in the primary health care system, located at the village level in rural areas. Mental health skills should be taught to primary care workers, who would need to be supported by some kind of specialist psychiatric back-up. The concept of a mental health extension worker, or some kind of "link worker", who would work close to the community, was developed in several of the responses. The importance of such a worker liaising with traditional healers and spiritual leaders was repeatedly emphasized. The main tasks for this person were seen as providing support to families and helping to maintain patients in their homes. He/she was also expected to be able to detect relapse and refer to the next level of the primary health care system when appropriate. At the health centre level, some respondents felt that more specialized, mental health expertise should be available: for example, community health workers with special skills in mental health.

Regarding the training for these mental health workers, most recommended development of standardized training packages, complemented by on-the-job training. The necessity for ongoing monitoring with specialist back-up was stressed. Regular refresher courses were thought to be important, preferably short and frequent courses rather than long ones with extended intervals in between them.

The absolute necessity of a reliable supply of essential medications, seen to be a chronic problem in most African countries, was a prominent comment. The need for transport facilities for outreach and attending to the logistical

aspects of providing care was particularly stressed by those respondents who might be expected to be closest to the coal-face of mental health care provision, the clinical officers and nurses.

Concerning factors which protect against mental disorder, almost everybody mentioned the extended family and associated social support as being a positive and protective feature of life in traditional African societies. The sense of belonging to the community and the presence of connections with other members of the community, ancestors and the land, as well as collective responses to suffering, were features seen as advantageous to mental health. The valuable role of sociocultural beliefs in giving meaning to the experience of mental disorder and facilitating healing was also mentioned. A number of respondents emphasized that communities should be encouraged to value and appreciate what they have and avoid uncritical acceptance of Western ideas. Economic support of patients and their families, together with provision of effective modern psychiatric care, was also seen as an important strategy for supporting the beneficial fabric of traditional life.

Perceived disadvantages of traditional African societies reported by respondents included the presence of high expressed emotion within families, a lack of individuality in psychological functioning, a lesser focus on individualized human rights and the associated tendency towards overriding patient autonomy. An unrealistic expectation of the Western medical model was another issue raised: for example, patients expecting fast and complete cures. Some directly harmful aspects were mentioned, including chaining, beating, fumigation and other violating traditional practices. The cultural use of psychoactive substances such as khat, cannabis and alcohol was also mentioned by respondents as a potential threat to mental health. Some respondents highlighted the role of childrearing practices that might be harmful.

It was suggested that community primary health care workers should be properly informed about good and bad aspects of traditional therapies for mental disorder, and use this knowledge to sensitize community members and traditional healers to the dangers and to the existence of effective alternatives. By increasing involvement of the patient, family and community in mental health care, it was thought that safe and effective practices could be disseminated. Equipping a few key influential community members with knowledge regarding mental health issues was proposed as an effective strategy for countering stigmatizing attitudes and harmful practices.

## DISCUSSION

Although the number of responses was limited, we consider the above views to have useful bearing on the question of how to develop community-based mental health care in sub-Saharan Africa. The respondents included a number of

leading mental health professionals in their countries and persons with direct experience in the provision of care.

The key WHO proposal that mental health services should be integrated into primary health care (7,8) was supported by all respondents. In most African countries this basic infrastructure of primary health care does exist and studies have demonstrated that those who are already working in these settings can be equipped with basic mental health skills. In our survey, however, primary health care workers devoted to mental health issues were also thought to be required for effective provision of community care. The reasons underlying this suggestion deserve further exploration, as they may reflect dissatisfaction with the quality and effectiveness of mental health care that generic primary health care workers are realistically able to provide. Such real-life evaluations of mental health care provided within primary health care in rural sub-Saharan settings are essential to direct policy in this area.

A critical issue to be addressed is how to provide primary health care workers, generic or specialized, with appropriate supervision and continuing education. Our survey indicated failings in current arrangements. Poor support in the field, together with inadequate remuneration, are likely to fuel the high turnover of staff which undermines every effort to expand provision of mental health care.

Another area highlighted by our survey is the importance of the relationship between community mental health care workers and traditional healers. It is well-recognized that a wide diversity of healers deal with mental health issues in traditional African societies: religious healers, herbalists, those practicing sorcery and witchcraft, as well as spiritual healers based on other traditional belief systems. The need to find ways to collaborate with all these different groups was emphasized already at the First Pan African Psychiatric Conference in Abeokuta, Nigeria, in 1961 (9), but remains a pressing issue according to our respondents. We consider the prominence given to this issue by our respondents to be an important change from earlier days when modern medicine tended to have a negative and distancing attitude towards traditional healers. Dissemination of successful strategies for collaboration and further scientific evaluation of potential models would be timely in this climate of receptiveness.

The particular needs of urban and rural populations were seen as a high priority to be addressed. The majority of people in sub-Saharan Africa are still living in rural areas, where there is a lack of specialist back-up, grave problems retaining trained health workers and difficulties with transportation. In urban areas the challenges are different: over-crowding, abuse of alcohol and other substances, commercial sex working, child labour, homelessness, mentally ill migrants and many other problems associated with the rapidly growing cities.

All this taken together tells us that it is time for some kind of pan-African initiative to develop mental health services according to the special needs and the social and

cultural conditions in sub-Saharan Africa. Efforts to date have been laudable, but limited in their impact at the grass-roots level. The WHO has taken the initiative up to now and is probably the best-placed organization to restart the movement towards a truly community-based mental health system for the people of sub-Saharan Africa. We hope the opinions in this paper will spark the debate.

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